January 25, 2016

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Johnny Isakson
United States Senator
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Mark R. Warner
United States Senator
Committee on Finance
United States Senate
Washington, DC 20510-6200

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The SCAN Foundation (Foundation) welcomes the opportunity to submit comments to the U.S. Senate Committee on Finance (Committee) on the *Bipartisan Chronic Care Working Group Policy Options Document*. The Foundation is an independent public charity devoted to transforming care for older adults in ways that preserve dignity and encourage independence. The Foundation envisions a future where high-quality, affordable health care and supports for daily living are delivered on each person's own terms, according to that individual's needs, values, and preferences.

The following comments are organized to respond to specific sections of the Committee's *Policy Options Document* relevant to the Foundation's priorities and areas of expertise. Our comments elevate how principles of person-centered care impact service delivery, providing the flexibility

needed to meet individual health and non-medical needs. In addition, we reiterate comments the Foundation provided on June 10, 2015 regarding the importance of including function when determining eligibility and types of services provided.

Expanding Independence at Home Model of Care

Alternate methods to identify people with multiple chronic conditions: The Foundation appreciates the Committee's inquiry regarding eligibility for the CMS Independence at Home demonstration, if it were made permanent and expanded nationwide. We recommend adoption of a single comprehensive assessment that identifies both health and functional needs. A report by Avalere Health describes the value of targeting services based on a comprehensive assessment and implementing person-centered care coordination. The research demonstrates that an enhanced health risk assessment used by Medicare Advantage plans assessing medical, social, and functional needs can identify individuals who would benefit from care coordination. Similarly, a comprehensive assessment that includes function could identify individuals for an Independence at Home model of care, either by extending health risk assessments to fee-for-service providers or by implementing a single comprehensive assessment. Further, data from the National Health and Aging Trends Study (NHATS) can be used to specify the elements that identify functional need, thereby informing which data should be collected. Ultimately, a comprehensive single assessment combined with appropriate data collection can evaluate individuals' needs in a consistent manner, providing health and functional data to identify eligible individuals and their scope of need.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

High-severity chronic care management code criteria: The Foundation believes that both clinical and functional status affects an individual's health and well-being, and therefore influences the care management process. To this end, we recommend that both clinical and functional status be assessed. We support the Committee's consideration of functional status as criteria for the new high-severity chronic care management code being considered. When considering functional status and eligibility criteria for the new care management code, we recommend clarifying whether eligibility would be based on an individual's functional ability in the absence or presence of services and supports. An individual's ability can change with the correct services and supports in place, potentially resulting in less need for intensive care management. In addition, we recommend that care management codes be designed with flexibility to enable individuals to transition between codes with ease. Alternatively, the high-severity chronic care management code should allow for variation in rate of use depending on whether the individual is experiencing a crisis, receiving support and coaching to improve their health, or stable either with or without supports.

Impact measurement: The Foundation believes that quality outcomes can be achieved through person-centered care coordination based on a comprehensive assessment that informs the care plan by identifying the individual's needs and preferences. Systems that champion person-centered care measure success by what matters most to individuals, such as how to live with complex needs and achieve individual goals. In 2015, the Foundation partnered with the American Geriatrics Society and

University of Southern California to convene experts to create a formal, actionable definition of person-centered care. The American Geriatrics Society released a group of reports defining and operationalizing person-centered care. We recommend that high-severity care management use a comprehensive assessment that includes functional status to target care management, implement evidences-based care management programs, and measure impact in congruence with the individual's identified goals.

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

Process for identifying the chronic diseases for which MA plans benefits would be tailored: Providing Medicare Advantage plans with flexibility to tailor benefits to meet an individual's needs based on his/her chronic conditions can allow for more person-centered care. We believe the benefit packages should not be prescriptive as one size does not fit all. A chronic condition can affect people in different ways, especially if experiencing interactions between multiple chronic conditions. As stated above, considering only an individual's diagnosis is not sufficient to acquire the positive outcomes sought by the Committee. We recommend that an individual's functional ability should also be assessed when identifying care needs and services, particularly for individuals with multiple chronic conditions.

Requirements to ensure benefit design change improves care: The Foundation believes that benefits should align with an individual's health and functional needs, goals, and values. Recent articles published in the *Journal of the American Geriatrics Society* define person-centered care and describe ways in which organizations use person-centered care for high-need/high-risk older populations. We recommend the Committee develop policy that clearly defines person-centered care and establishes it as a core principle in service delivery for this population.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

New supplemental benefits criteria: The Foundation recognizes the importance of integrating medical and non-medical care to address social determinates of health. As previously stated, person-centered care identifies and provides the right services at the right time in order to meet the individual's health and functional needs while considering his/her goals, preferences, and values. By adopting key elements of person-centered care as highlighted in recent articles, we believe providers could connect individuals with the social services that align with the needs and goals identified in the care plan. To this end, we recommend providers be responsible for connecting individuals with community-based services (i.e., behavioral health, personal assistance services, housing supports).

Additionally, California is in the process of implementing a CMS Financial Alignment Demonstration (Cal MediConnect) integrating Medicare and Medicaid services, requiring plans to coordinate care while providing flexibility to furnish additional social services. Early evaluation results and success stories show that individuals receiving care coordination are satisfied with their care, are accessing services they did not previously know existed, and are seeing improvements in their quality of life. Additional information from the evaluation's telephone survey will shed light on the types of benefits

provided and may be useful to informing decisions about the types of supplemental benefits Medicare Advantage plans could provide to similarly vulnerable population of Medicare-only beneficiaries. These survey results are anticipated in the summer of 2016.

Safeguards for new supplemental benefits to prevent abusive practices or inappropriate enrollment: As stated above, person-centered care is a process in which the team of providers, together with the individual receiving care, identifies goals and develop a person-centered plan thereby creating a system of accountability. The care plan should identify formal services, including those provided through health insurance or other funding sources, and informal services (i.e., unpaid support provided by family and friends). A comprehensive assessment and person-centered care plan create sources of data that can be used to ensure accountability and assess quality outcomes.

Ensuring Accurate Payment for Chronically Ill Individuals

Study examining functional status: The Foundation is pleased that the Committee is considering a study to examine whether data on functional status could improve the accuracy of risk-adjustment payments. In 2011, the Foundation commissioned an analysis of the cross-section between chronic illness and functional status from a federal payer perspective and found powerful results. Over 30 percent of older Medicare beneficiaries in the top spending quintile have both chronic conditions *and* functional limitations. On average, Medicare spends almost three times more per capita on seniors with chronic health conditions and functional impairment compared to seniors with chronic conditions alone. This analysis elevates the importance of giving equal consideration to an individual's functional status along with their health status in order to target care and develop appropriate risk-adjustment payments that incentivize coordinated care.

Developing Quality Measures for Chronic Conditions

Quality measures for person-centered care: There has been much attention to developing quality measures for individuals with multiple chronic conditions, including a strategic framework put forward by the U.S. Department of Health and Human Services in 2010 and another from the National Quality Forum in 2012. Health care quality measures primarily have a clinical focus, and do not consider what is important to the individual. There is a critical need to expand the definition of quality to include how individuals experience their care, especially the coordination of medical and non-medical services. The Foundation is collaborating with experts to develop performance measures focused on person-centered outcomes identified as important by older adults that can be used in quality oversight. While this work is in its beginning stages, we recommend the Committee consider policy to incorporate person-centered quality measures, focusing on individuals with multiple chronic conditions and functional impairment. This lens broadens the opportunity to address quality of services across the continuum of medical and social supports that together influence an individual's health and well-being.

Encouraging Beneficiary Use of Chronic Care Management Services

Waive cost sharing for chronic care management: Waiving cost sharing for chronic care management will reduce barriers to accessing care management services, and will reduce confusion and administrative barriers for providers. We believe cost sharing deters individuals from accepting care management services, especially if providers bill for care management activities that do not include the individual, such as consultation between providers. We believe there is great potential to improve quality and reduce health care costs by providing care management services that do not require cost sharing. In fact, a study released in 2014 showed that certain care coordination models can provide a return on investment if assessments using functional data are used to target services. Further, regardless of cost sharing policies, we believe it is important that providers inform and educate beneficiaries about care management services and their benefit. In California, evaluation of the Financial Alignment Demonstration (Cal MediConnect), shows that individuals lack awareness of a care coordinator or care manager, but do understand that a nurse (or other professional) discussed care options with them. We recommend that the Committee requires providers to explain the care management services and how these services may be delivered, so individuals are not confused when they receive a summary of benefits with care management indicated.

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

Disease scope for Medicare covered planning visit: While disease scope should be considered in determining eligibility for a Medicare-covered planning visit, it does not entirely reflect an individual's needs and how the disease affects interaction with the external environment. We recommend the Committee also considers functional status as criteria, and encourage the use of a standardized comprehensive assessment to determine disease scope and functional ability which can be used to develop a person-centered care plan.

Payment code requirements: Providing a one-time payment to clinicians to address planning needs of individuals newly-diagnosed with a serious or life-threatening illness is a step toward supporting a person-centered planning process. However, an individual's health and non-medical needs often change over the progression of the illness, which may require ongoing care coordination versus one planning visit when first diagnosed. We recommend the Committee develop policy establishing criteria for person-centered planning that incorporates individual's health needs, goals, and values. This plan should identify the individual's goals, plan to meet those goals, and services needed. If ongoing care management is identified as a needed service, we recommend that the provider could implement the appropriate care management process and code at a future point in time.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

Process to reduce cost sharing: We recommend establishment of a standard for reducing cost sharing for services. Federal policy makers can waive the cost sharing fees for individuals receiving services through an ACO through a CMS payment waiver or legislative authority.

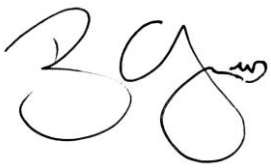
Waiving cost sharing to incentivize beneficiaries to access services: Cost sharing can be a barrier to accessing services, especially as there are competing demands on personal budgets to manage chronic conditions. Supplemental plans vary, and do not always cover all cost sharing. Individuals face the financial demands of cost sharing for medical services, transportation to appointments, medication, medical equipment, nutrition, etc. Reducing cost sharing removes one element, and frees up funds to cover other necessary costs that contribute to an individual's health and well-being. While cost sharing is one barrier to accessing services, other barriers may prevent people from accessing services. We recommend the Committee study the scope of barriers to identify the most effective solutions. The Foundation continues to recommend the benefits of person-centered care defined and operationalized in materials released in late 2015. Person-centered care engages an individual in his/her care by focusing care on what is important to the person.

Increasing Transparency at the Center for Medicare & Medicaid Innovation (CMMI)

Frequency of required rulemaking for innovative payment and service delivery models: The Foundation appreciates the Committee's desire to increase transparency at CMMI. However, the proposal to require CMMI to issue notice and comment rulemaking for innovation models might hamper the innovation process. We recommend other methods for expanding transparency in CMMI's overall process, such as creating open access to the Medicare Shared Savings Program (SSP) portlet and associated newsletters.

Thank you for the opportunity to provide input on the policy options under consideration by the Chronic Care Work Group. The Foundation believes that targeted care coordination and person-centered care are essential components to addressing the needs of older adults and people with disabilities receiving services through Medicare. There is significant work being done to determine how best to coordinate services to improve health, reduce cost, and ensure quality care. The Foundation is happy to serve as a continued resource to the Committee as this important policy work continues to improve care for Americans living with multiple chronic conditions.

Sincerely,



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